Disability Rights Connecticut
"Connecticut's protection and advocacy system"

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Testimony Concerning SB 15 and HB 5042 Before the Insurance and Real Estate Committee

Good afternoon, members of the Insurance and Real Estate Committee:

My name is Sheldon Toubman and I am the Litigation Attorney at Disability Rights CT. We are the Protection and Advocacy System for CT, serving individuals with a full range of physical, behavioral, intellectual and developmental disabilities. I am here to testify about the impact on people with disabilities of provisions in **SB 15 and HB 5042**, which together seek to implement the Office of Health Strategy's "Primary Care Roadmap" and "Cost Growth Caps." **Taken together, these bills will likely harm access to health care for *all* patients, but particularly people with disabilities, elderly individuals and Black and brown people who already suffer health disparities.**

Under the OHS Primary Care Roadmap, parts of which are codified in **SB 15**, the intention is to move large sums of money - about $3.9 billion/year by 2025 - to primary care and **away** from other areas of health care, including areas that actually need more money. In my experience, this includes providers of behavioral health services, dental care, in-home providers and Personal Care Attendants, where there is a general recognition that rates are inadequate.

Under OHS's related Cost Growth Cap proposal codified in **HB 5042**, another goal is to **cap total annual health expenditures**. Accordingly, shifting large sums of money to primary care providers necessarily means there will be *less* to go around to pay for these other services where access is recognized to be a significant problem.

The Roadmap also includes a radical proposal to pay all primary care providers under all health plans on a "capitated" basis, meaning that providers no longer

get paid for seeing patients - they get the same fixed payment per member per month (pmpm) if they see the patient once, twice or not at all. OHS proposes to codify this in **HB 5042**, which will expressly give it power for "directing" and "monitoring the adoption of *alternative payment methodologies.*" While the bill does not say this, the agency's Roadmap report, as well as its Roadmap update document circulated to legislators on February 23, makes clear that this means **capitated payment for all primary care providers** (sometimes euphemistically called "prospective payment").

This payment system will incentivize primary care providers to deny office or telehealth visits and send patients to specialists instead. This will in turn make it harder for patients to see those specialists, especially since, while getting more referrals, the specialists' payment rates will likely need to be **cut** – in order to divert money to the primary care providers now paid for not seeing patients. In the case of Medicaid, there is already a significant access problem for specialists, who only are paid at 57% of what Medicare pays for the same services (CT Medicaid pay 96.5% of what Medicare pays for primary care services).

While the radical capitation proposal is intended to apply to all payers, state officials can only really control the Medicaid program, so it will definitely be imposed on Medicaid, which disproportionately serves Black and brown individuals, seniors, and people with disabilities, exacerbating the health disparities already being experienced by these individuals. This is exactly what happened with OHS's previous initiative, the State Innovation Model (SIM).

Finally, I would like to address some of the misrepresentations by OHS in support of its Roadmap and these two bills, in its February 23rd update to legislators:

1. "**Provider participation in any strategies included in the Primary Care Roadmap is voluntary**." It is not voluntary for CONSUMERS, so if the provider or the large health system they work for exercises the "choice" to accept capitation because they think it will increase their revenue or profits, the consumer has no choice in the matter.

2. "**The Primary Care Roadmap seeks to address issues of health equity promulgated by our current system."** A major aspect of health disparities is under-service for Black and brown people and people with disabilities. **Capitation of providers necessarily incentivizes further underservice**, since the provider gets

paid the same payment per member per month if providing no services or providing office or telehealth appointments. The capitation part of the Roadmap will EXACERBATE health inequity in our current system.

3. **"Fewer medical students entering primary care, an aging primary care workforce, and high levels of burnout, are threatening our primary care infrastructure."** To whatever extent this is true, that is not where the crises in workforce are- in my experience, the problems with inadequate workforce are in behavioral health, dental services, PCAs and home health aides, as well as specialty care, not primary care.

4. **"OHS has initiated an intensive community outreach effort to hear from patients and consumers about the Primary Care Roadmap components**." We will be happy to provide further input to OHS. However, based on past experiences, OHS will conduct targeted listening sessions but then only report on the part of what they hear which is marginally supportive of OHS's general goals, while ignoring all of the objections - as with its last attempt to impose capitation on primary care -- to get to those goals. We are already seeing this in OHS's failure to publish the many negative comments it received in response to the draft of the Roadmap by its January 14th deadline, as it previously promised to publish. Although advocates understand that there are over 100 negative comments, OHS is withholding this information from the public and legislators.

5. **"Current primary care prospective payment models in other states and those advocated for by national leading organizations are far different than those first tried decades ago."** "Prospective payment" is a euphemism for capitation and it creates the same basic incentives to deny care as always under these payment schemes, long proposed to save money. No one has yet devised the means to prevent the harm that capitation incentivizes. Risk adjustment in the form of higher pmpm payment for more complex individuals does not change the basic incentive for primary care providers to **not** see these patients and routinely send them out to specialists instead, while keeping higher pmpm payments. Metrics cannot detect the many ways underservice will be incentivized. Medicare has been trying these payment models and none have demonstrated meaningful savings or quality improvement.

Thank you for the opportunity to speak with you today.